TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ALLIED MEDICAL CENTERS

Respondent Name
SOUTHERN VANGUARD

MFDR Tracking Number
M4-11-2452

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial explanation is understandable, it does not apply in this instance. The denial code and their description are too vague for our facility to determine the basis for the denial. This denial is not in compliance with Rule §133.3."

Amount in Dispute: $905.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 5/20/10, Respondent filed a PLN-1 which stated that the Claimant's workers' compensation claim was denied as the injury did not arise out of and in the course and scope of employment. This PLN further states that the claim was received on 5/7/10. Requestor's bill was denied for this reason."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 1, 2010 through September 23, 2010	97110-GP-59, 97112-GP-59, 97140-GP-59, 99213 and 99080-73	$905.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 96 – Non-covered charge(s)
   - 878-012 Denied: Workers' Compensation benefits have been denied based on the workers' compensation law in the state the claim was filed

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The medical fee dispute referenced above contains information/documentation that indicates there are **unresolved** issues of compensability, extent-of-injury and/or liability (CEL) for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code "96 – Non-covered charge(s)" and "878-012 Denied: Workers' Compensation benefits have been denied based on the workers' compensation law in the state the claim was filed."

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   28 Texas Administrative Code §133.307(e)(3)(H), requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to 28 Texas Administrative Code §124.2 of this title. The appropriate dispute process to resolve issues of compensability, extent of injury and/or liability requires the filing of a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. The division will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals.

   Review of the submitted documentation finds that there are unresolved issues of compensability, extent of injury and/or liability for the same service(s) for which there is a medical fee dispute. The requestor submitted insufficient documentation to support that the issue(s) of compensability, extent of injury and/or liability were resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 6, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.